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Health Care Eligibility Benefit Inquiry and Response (270/271)

User and Companion Guide for the Extranet

Version: R20080301.00

Effective: April 2008

Changes in the April 2008 Release

This document replaces the Health Care Eligibility Benefit Inquiry and Response (270/271) User and Companion Guide for the Extranet released on November 11, 2007.

SECTION CHANGED	DESCRIPTION OF CHANGE
Section 4 – Eligibility Reporting	Add fourth bullet from the end to explain that Medicare Part D and Managed Care Organizations will include plan enrollments for a specific period. Beneficiaries may change plan enrollments many times without changing the Medicare Part D or Managed Care Organizations.
Section 4.3.2 – Information Receiver Level Structures	Update this section to reflect that May 23, 2008 will be the date Medicare as a payer mandates use of National Provider Identifier (NPI)
Section 4.5.2 – Information Source and Receiver Level Data, 2100B Loop	AAA03 Reject Reason Code column, 43: Effective May 23, 2008, when any 2100B REF01 is 1C.
Section 4.5.4 – Subscriber Eligibility Benefit Information	• Add fourth and fifth paragraphs to explain the use of inactive status. • Add last two paragraphs to explain the use of the MCO Type Codes, provide the web link where plan contact information can be found, and the treatment of Managed Care plans that also provide Part D coverage.
Section 5 – 271 Response Data Elements, Part A/B Entitlement/Term Dates	• 2110C, EB04 add "or omit EB04" and add footnote 4: "EB04 will be omitted when periods of ineligibility apply to both Medicare Part A and Medicare Part B." • 2110C, DTP add footnote 5: "DTP will be included only if the inactive period is for a specific date range."
Section 5 – 271 Response Data Elements, Home Health Data - HHEH	• HHEH – Add PRV02 qualifier "HPI" for NPI at 2120C loop • Add a footnote to indicate that the legacy provider number will be returned if the NPI is not in the Information Source.
Section 5 – 271 Response Data Elements, Occupational Therapy and Physical/Speech Therapy caps.	• Add new sections for Occupational Therapy and Physical/Speech Therapy caps. • Add footnote 12 for both Occupational Therapy and Physical/Speech Therapy caps that says "Occupational Therapy Caps and Physical/Speech Therapy Caps will be implemented beginning from calendar year 2007. Therapy cap values for 2006 are not available."
Section 5 – 271 Response Data Elements, Hospice, NM Segment	• Hospice – Add XX for NM108 • Add footnote 13 to indicate that the legacy provider number will be returned if the NPI is not in the Information Source.
Section 5 – 271 Response Data Elements, Blood Deductible Units	Add a section for Blood Deductible Units.

SECTION CHANGED	DESCRIPTION OF CHANGE
Section 5 – 271 Response Data Elements, Part D Data	• Add a section for Medicare Part D Data. • Add footnote 14: "Medicare will use the "OT" qualifier to represent Part D plans per the ANSI ASC X12N 270/271 version 005010X279 which states "When this code is returned by Medicare or a Medicare Part D administrator, this code indicates a type of insurance of Medicare Part D." • Add footnote 15: "Telephone numbers will be sent when the data becomes available."
Section 5 – 271 Response Data Elements, MCO Data	• Add the following qualifiers to Loop 2110 C, Element EB04: IN, OT, PR, PS. • Clarify that the Contract Number and Plan Number separated by a space will be returned in Loop 2110 C, Element REF02.
Section 5 – 271 Response Data Elements, MCO Data	• Add PER Segment with PER01=IC, PER03=TE, PER04=Telephone Number. • Add footnote 16: "Telephone numbers will be sent when the data becomes available."

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1 Introduction

1.1 Scope

The purpose of this document is to define the Medicare eligibility inquiry sent from authorized submitters and the corresponding response in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to implement the HIPAA administrative simplification provisions, the 270/271 has been named under 45 CFR 162 as the Electronic Data Interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response.

The software is based on the ANSI ASC X12N 270/271 version 004010X092A1 implementation guide that may be found at the following web site: www.wpc-edi.com/HIPAA. The 270/271 is a "paired" transaction (the 270 is an in-bound eligibility inquiry and the 271 is an out-bound eligibility response).

This instructional manual has two purposes. The first purpose is to educate the user on how to access the system. The second purpose is to educate the user on how to send and read eligibility inquiries and responses using the 270/271 formats and convey all Medicare required business rules and information to interpret the information being received.

Providers and Clearinghouses may implement a real-time ANSI ASC X12N 270/271 version 004010X092A1 eligibility inquiry/response to request coverage information from Medicare on patients for whom services are scheduled or services have already been delivered. Providers and Clearinghouses will be referred to as “Trading Partners” throughout this document.

1.2 System Overview

The system will provide access to Medicare beneficiary eligibility data in a real-time environment. In a real-time mode, the Trading Partner transmits a request transaction either directly or through a switch (Clearinghouse), and remains connected while the receiver processes the transaction and a response is returned.

Trading Partners will access the CMS Data Center via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN) to send their eligibility request. This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.

For a 270 real-time inquiry, the software at the CMS data center will translate the incoming 270, perform validations, request Beneficiary eligibility information from the CMS eligibility database, and create either a 271, 997, TA1 or a proprietary response.

CMS will continue to hold the Clearinghouses responsible for the privacy and security of eligibility transactions sent directly to them from Providers, and requires them to be able to associate each inquiry with a Provider. Provider authentication must be established outside of the transaction. Trading Partners must not send User IDs and passwords within the 270 eligibility transaction.

2 Electronic Data Interchange (EDI) Registration

In order to obtain access to the CMS 270/271 Medicare Eligibility transaction via the MDCN a Submitter must access the appropriate forms located on the CMS website dedicated to the HIPAA Eligibility Transaction System (HETS) Help (270/271).

Access to Sign Up page is:
http://www.cms.hhs.gov/HETSHelp/02_SignUpNow.asp#TopOfPage .

Read and follow the instructions found at the above link to complete the sign up process.

3 Help Desk Access and Support

The Medicare Eligibility Customer Service Help Desk will be available from 7:00 AM to 9:00 PM EST, Monday - Friday. The Help Desk is the single point of contact for all questions or concerns about the system.

The Contact Number for Help Desk is 1-866-324-7315.

The email address for the Help Desk is: MCARE@CMS.HHS.GOV

3.1 Testing Requirements

Trading Partners are required to submit test transactions to ensure that their systems creating and transmitting the data are HIPAA and X12 compliant. Each Trading Partner can submit up to 50 test transactions during the testing phase. Trading Partners must call the Help Desk to coordinate test data and testing procedures.

Trading Partners can call the Help Desk for assistance in researching problem transactions. The Help Desk will not edit Trading Partner eligibility data and resubmit transactions for processing.

4 Eligibility Reporting Instructions

The Centers for Medicare & Medicaid Services (CMS) implemented the 270/271 transaction set as a real-time transaction for a single request. The data available through this transaction set allows a provider to verify an individual's Medicare eligibility and benefits.

Since eligibility information is designed to support the payment of claims, and the usual time limit for submitting claims is within 15 to 27 months of the date of service (depending on the month of service), the information source will be purged quarterly of all data older than 27 calendar months. Medicare regulations allow an exception to the timely filing requirements in cases of the Medicare program's administrative error. In the rare situation where eligibility information older than 27 months may be needed, Provider Contact Centers (PCCs) are available to assist providers or their representatives. The PCC representatives have access to the complete history of eligibility data from the source databases.

To avoid misunderstandings and variations in responses, requests older than 27 calendar months will be rejected with the error 2100C AAA03 = 62 – Date of Service Not Within Allowable Inquiry Period. CMS will compare the requested date on the 270 to the calculated date; based on

the date the transaction was received by the CMS system minus 27 calendar months, to determine the eligibility window.

Trading Partners and CMS will comply with the following:

- Each transaction will contain only one Patient Request. Each 270 can have only one ISA-IEA, one GS-GE, one ST-SE and a single 2100C subscriber Loop. Transactions sent with multiple ST-SE segments will return response for only a single patient request. The response may be for any one of the multiple patient requests (ST-SE) submitted on the 270 transaction.
- The system will ignore dependent level data if sent with a 270 request and will return response only for the subscriber level information.
- The system will respond with current eligibility information if no specific date request is contained in the 270 request; or if the 270 request contains a date which is the same as the system processing date.
- Current eligibility information will contain the most recent benefit information for a patient.
- The system will respond with benefits provided only for a specific period if the date or date range contained in the 270 request is for the specific period. The system will accept requests for specific periods up to 27 months in the past and up to 4 months in the future.

  The following table provides some examples:

If today's date is:	Historical requests accepted for:	Future requests accepted for:
April 2008	January 2006	August 2008
March 2008	December 2005	July 2008
February 2008	November 2005	June 2008
January 2008	October 2005	May 2008

- Benefits provided for a specific period will include Part A spells that fall within 60 days of the date or date range contained in the 270.
- Benefits provided for Medicare Part D and Managed Care Organizations will include plan enrollments for a specific period. Beneficiaries may change plan enrollments many times without changing the Medicare Part D or Managed Care Organizations.
- The system will return core eligibility information if no service type code is sent on the 270.
- Eligibility for preventive services, whether Healthcare Common Procedure Coding System (HCPCS) or Smoking Cessation Counseling, will be returned as part of core eligibility information regardless of which service type codes are sent. Note: Preventive care information displays current information only. No inference about historical eligibility can be made based on next eligible dates.
- The response is based on information obtained from the CMS database at the time of inquiry and is not considered a guarantee of payment.

4.1 Real Time Communications Transport Protocol

Communications through the Extranet to the CMS data center will be via the TCP/IP streaming socket protocol. Trading Partners can submit multiple 270 transactions without waiting for a response before triggering the next 270. Trading Partners must ensure that the session remains connected until all responses are received. Each submitted transmission shall contain one 270 transaction with only one ISA and IEA segment, along with a transmission wrapper around the 270 transaction. The transmission wrapper Header/Trailer has no Segment ID associated with it and requires the length of the transaction message. There will be no handshake after the connection is accepted with the first submitted transmission.

Outbound response transactions will have the same format transmission wrapper. The response to the submitter will be returned in the same session in which the 270 was submitted.

Standard format of the TCP/IP Communication Transport Protocol Wrapper:

SOHLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX

SOH = Required (1 positions), must be ASCII - 01

LLLLLLLLLL = Required (10 positions), Right justified with zero padded

Note: Length of the HIPAA 270 transaction not including Transmission wrapper data.

STX = Required (1 positions), must be ASCII - 02

<HIPAA 270 Transaction> = Required (HIPAA 270 – ISA-IEA)

ETX = Required (1 positions), Must be ASCII - 03

Note: For more details about SOH, STX and ETX see the Health Care Eligibility Benefit Inquiry and Response 270/271 ASC X12 Extended Control Set in the ASC X12 Standards for Transactions 270/271 004010X092A1 Implementation Guide.

4.2 Eligibility Search Options

The Subscriber Level (Loop 2100C) must contain the Patient Information to query Medicare eligibility. The following data elements are required to search and identify a Medicare beneficiary:

- Patient’s Medicare Number (HIC Number or RRB Number)
- Patient’s Date of Birth
- Patient’s Full Last Name
- Patient’s Full First Name

If all four of these elements are present, a response will be generated if the Patient’s Medicare Number is found in the database. If the Patient's Medicare Number submitted is found but is not the current number, the cross-referenced Medicare Number will be returned so that the transaction may be resubmitted with the correct Medicare Number. If the Patient’s Medicare number is not found, or one or more of the above data elements does not match in accordance with the system matching algorithms, the system will generate the appropriate AAA03 error in the 271 response.

4.3 Interchange Envelope and Functional Group Structures

Trading Partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Functional Acknowledgement (997) guidelines for HIPAA in the X12 Implementation Guides in Appendices A and B. Trading Partners must also follow the basic character set guidelines as set forth in the implementation guide.

Trading Partners must use the preferred delimiters conveyed to CMS during the EDI Registration process. The system will always construct 270 responses with the delimiters agreed upon during the EDI Registration process.

Trading Partners will receive a 271 2100A AAA03=42 response when the system is unable to process a single transaction in under a minute. If the incoming 270 transaction is not X12 compliant, then the 271 response will return an error.

The following are specific requirements for the ISA and GS Headers:

Segment/ Element	Attributes			Element Name	Instruction
ISA	**Interchange Control Header**				
ISA01	R	ID	2/2	Authorization Information Qualifier	00 – No authorization information must be present in ISA02
ISA02	R	AN	10/10	Authorization Information	Blanks
ISA03	R	ID	2/2	Security Information Qualifier	00
ISA05	R	ID	2/2	Interchange ID Qualifier	ZZ – Mutually Defined
ISA06	R	AN	15/15	Interchange Sender ID	Trading Partner Submitter ID
ISA07	R	ID	2/2	Interchange ID Qualifier	ZZ – Mutually Defined
ISA08	R	AN	15/15	Interchange Receiver ID	‘CMS ’
ISA14	R	ID	1/1	Acknowledgment Requested	0 – No acknowledgment requested. CMS will not acknowledge receipt of real time transaction and will process the transaction even if acknowledgment is requested.
GS	**Functional Group Header**				
GS02	R	AN	2/15	Application Sender’s Code	Trading Partner Submitter ID
GS03	R	AN	2/15	Application Receiver’s Code	CMS

4.3.1 Information Source Level Structures

CMS will be the Information Source for all Medicare Eligibility Transactions. Providers and Clearinghouses must submit the BHT03 reference identification to uniquely identify each transaction. Trading Partners must follow the specific requirements for the BHT and Information Source:

Loop	Segment Element	Attributes			Element Name	Instruction
Header	**BHT**	**Beginning of Hierarchical Transaction Set Header**				
Header	BHT02	R	ID	2/2	Transaction Set Purpose Code	All codes are acceptable.
Header	BHT03	R	AN	1/30	Reference Identification	Reference Identification is required for Real-time inquiry.
2100A	**NM1**	**Information Source Name**				
2100A	NM101	R	ID	2/3	Entity Identifier Code	PR
2100A	NM102	R	ID	1/1	Entity Type Qualifier	2
2100A	NM103	R	AN	1/35	Last/Organization Name	CMS
2100A	NM108	R	ID	1/2	Identification Code Identifier	PI
2100A	NM109	R	AN	2/80	Identification Code	CMS

4.3.2 Information Receiver Level Structures

Clearinghouses that submit transactions on behalf of the provider must ensure that the correct, valid and active Medicare provider identification is submitted as the Information Receiver. Effective on May 23, 2008, when Medicare as a payer mandates use of National Provider Identifier (NPI) only NPI provider numbers will be accepted.

Trading Partners must follow the specific requirements for the Information Receiver data:

Loop	Segment Element	Attributes			Element Name	Instruction
2100B	**NM1**	**Information Receiver Name**				
2100B	NM101	R	AN	2/3	Entity Identifier Code	1P
2100B	NM108	R	AN	2/2	Identification Code Identifier	Only Provider Qualifier “XX” will be accepted effective on May 23, 2008. Until then, Provider Qualifiers “XX” and “SV” will be accepted.
2100B	NM109	R	AN	2/80	Identification Code	When the Identification Code Identifier is ‘XX’ then this data element must be the Provider’s assigned NPI number; when the Identification Code Identifier is “SV’, this data element must be a valid Medicare Provider number.

Loop	Segment Element	Attributes			Element Name	Instruction
2100B	**REF**	**Information Receiver Additional Information**				This segment is situational. Effective on May 23, 2008, CMS will not return the contents of this segment.
2100B	REF01	R	ID	2/3	Reference Identification Qualifier	
2100B	REF02	R	ID	1/30	Reference Identification	

4.3.3 Subscriber Level Structures

Trading Partners must ensure that only one patient request is submitted in the Subscriber Level for each transaction. Trading Partners must follow the specific requirements for the Subscriber Level data:

Loop	Segment Element	Attributes			Element Name	Instruction
2100C	**NM1**	**Subscriber Name**				
2100C	NM103	R	AN	1/35	Subscriber Last Name	Last Name is required for Beneficiary Identification
2100C	NM104	R	AN	1/25	Subscriber First Name	First name is required for Beneficiary Identification
2100C	NM107	O	A/N	1/10	Subscriber Name Suffix	When the suffix is part of the Beneficiary's Last Name on the Medicare card, the suffix is required for Last Name matching.
2100C	NM108	R	ID	1/2	Identification Code Identifier	Subscriber Identifier must be MI.
2100C	NM109	R	AN	2/80	Identification Code	Beneficiary Health Insurance Claim Number (HICN) is required for Beneficiary Search or RRB (Rail Road Beneficiary number). This element must exactly match the ID on the patient's Medicare card.
2100C	**DMG**	**Subscriber Demographic Information**				
2100C	DMG02	R	AN	1/35	Subscriber Date of Birth	Date of Birth is required for Beneficiary Identification.
2100C	**DTP**	**Subscriber Date**				If Subscriber Date is not received, CMS will return the most current eligibility data of the patient, if coverage is indicated. CMS will accept dates up to 27 months in the past or up to 4 months in the future.
2100C	DTP01	S	ID	3/3	Date/Time qualifier	All codes are accepted. The same eligibility data is returned.
2110C	**DTP**	**Subscriber Eligibility Benefit Date**				CMS will not provide specific benefits for corresponding EQ if dates are sent with this loop. All benefits will be provided as of the 2100C DTP requested dates.

4.4 Proprietary Error Messages

Proprietary messages will be sent only when the ISA segment of the 270 cannot be read making it impossible to formulate an ISA segment for a response. The proprietary message will return error codes and description. Trading Partners may contact the Help Desk for assistance with Proprietary Errors. The format for the proprietary message is described below:

Data Element	Description	Size	Comments
Transaction ID	Transaction ID	04 characters	Data content will be "HETS"
Transaction Reference Number	Trace Identification No or (ISA13)	30 characters	Reference Number that Trading Partner can use to call Help Desk.
Date Stamp	System Date	08 Characters	CCYYMMDD
Time Stamp	System time	09 Characters	HHMMSSSSS
Response Code	Type of Error	02 Characters	See Below
	ISA	02 Characters	" I" the incoming ISA cannot be read.
Message Code	Error Code	08 Characters	Error code
Message Text Description	Error Descriptions	70 Characters	Error description

Proprietary Message Codes and Description

Response Code	Message Code	Message Text Description
I	HTS00101	Transmission Wrapper SOH (hex=01) is invalid or missing
I	HTS00102	Transmission Wrapper STX (hex=02) is invalid or missing
I	HTS00103	Transmission Wrapper ETX (hex=03) is invalid or missing
I	HTS00104	Transmission Wrapper Length is missing or not numeric
I	HTS00105	Transmission Wrapper Length does not match 270 transaction length
I	HTS00106	Transmission data is invalid or not ASCII
I	HTS00107	HIPAA 270 transaction does not start with ISA (Segment ID)
I	HTS00111	Transmission Inbound Message was empty
I	SBY00500	Inbound e*Xchange general processing error
I	SBY00502	Authorization for this transaction cannot be validated
I	SBY00503	Unable to interpret segment delimiter

4.5 Eligibility Response 271 Transaction Set Data Clarifications

The system will return eligibility information for a patient that has active Medicare Part A and/or Part B coverage. The ISA envelope will be formatted based on the information provided during the EDI Agreement and Registration process.

4.5.1 Security and Validation Edits

The system will validate that the Clearinghouse or Provider has been established in the Trading Partner Management System prior to processing the 270 transaction. If Trading Partner (ISA06)

cannot be validated, the system will return a proprietary message that states "Authorization for this transaction cannot be validated".

Trading Partners may not send transactions to be executed as Production (ISA15=P), until testing has been accomplished and approval to submit production transaction has been given. The system will return a TA105=020 Error for Invalid Test Indicator Value.

4.5.2 Information Source and Receiver Level Data

The system will return only one Transaction Set Header for each eligibility response. Trading Partners will receive the following AAA03 codes for Source and Receiver errors:

Loop	Element Name	Instructions	Element Name
2100A	AAA01 Yes/No Condition	AAA03 Reject Reason Code	AAA04 Follow up Action
2100A	Y	42 – When the system is unable to respond due to: • System is unavailable • Unable to format a response to the Trading Partner within 60 seconds • System hardware or software component(s) have failed • Databases have failed to respond	R
2100A	N	79 – When 2100A NM109 Source identification is other than 'CMS'.	C
2100A	N	T4 - when 2100A NM109 or NM103 is missing data for Information Source.	C
2100B	N	43 – Until May 23, 2008, when the Service Provider Number located at 2100B NM109 is missing or invalid; – Until May 23, 2008, when the Medicare Provider Number located at 2100B REF02 is invalid. – Effective on May 23, 2008, when the NM108 is not XX. – Effective May 23, 2008, when any 2100B REF01 is 1C.	C

4.5.3 Subscriber Level Data

The system will return only one Subscriber Level detail for each eligibility response. The system will use the elements described in ***Section 4.2 Eligibility Search Options*** to match a beneficiary record on the database.

The system will return the 2100C REF Segment from the 270 where REF01=EJ and REF02=Patient Account Number. REF03, description for the account, will not be returned even if sent on the 270 transaction.

The system will return the beneficiary address only if it is available in the CMS Eligibility database.

The system does not require the gender field to complete a Subscriber search; however, if sent in a 270 transaction, gender is a verified field and could cause transactions to reject. Trading Partners will receive the following AAA03 codes for Subscriber errors:

Loop	Element Name	Instructions	Element Name
2100C	AAA01 Yes/No Condition	AAA03 Reject Reason Code	AAA04 Follow up Action
2100C	N	58 – When the 270 2100C DMG02 element is missing Subscriber DOB.	C
2100C	N	62 - When the 270 2100C DTP03 element request date is more than 27 months in the past, or more than 4 months in the future.	C
2100C	N	64 – When the 270 2100C NM109 element is missing Subscriber ID, or the Subscriber ID is an invalid length.	C
2100C	N	65 – When the 270 2100C NM103 element is missing the Subscriber Last Name or; the matching algorithm of the Beneficiary Last Name on the 270 does not match the matching algorithm of the Beneficiary Last Name in the database.	C
2100C	N	65 – When the 270 2100C NM104 element is missing the Subscriber First Name; or the matching algorithm of the Beneficiary First Name on the 270 does not match the matching algorithm of the Beneficiary First Name in the database.	C
2100C	N	66 – When the 270 2100C DMG03 Subscriber Gender code does not match the Beneficiary Gender code on the database.	C
2100C	N	67 – When the 270 2100C NM109 Subscriber ID cannot be found in the Beneficiary database or HICN is inactive.	C
2100C	N	71 - When the 270 2100C DMG02 Subscriber DOB does not match the Beneficiary DOB on the database.	C

4.5.4 Subscriber Eligibility Benefit Information

The system will return a core set of eligibility information for all service type codes; or if service type code is not provided on the 270 transaction.

The system will return additional eligibility information along with the core eligibility data for certain service type codes. See '271 Response Data Elements' for a list of core and additional eligibility data elements returned on the 271.

The system will accept multiple service type codes on a 270 transaction. The system will return multiple EB loops based on the Type of Service Code request.

Medicare will return EB01=6 for specific dates to indicate periods of ineligibility, in addition to EB01=1 to communicate active status, when a beneficiary was ineligible for one of these reasons:

- The beneficiary has been determined to be an unlawful resident in the United States.
- The beneficiary has been deported from the United States.
- The beneficiary has been incarcerated and therefore not eligible for Medicare.

Information about which reason caused the period of ineligibility will not be released. EB04 will be omitted when periods of ineligibility apply to both Medicare Part A and Medicare Part B. Trading Partners should review the entire eligibility response to determine the appropriate eligibility status for the beneficiary.

When the following conditions exists the EB01=6 will be returned without any additional data:

- The beneficiary in the database does not have any entitlement information.
- The beneficiary is deceased and the Date of Death is prior to the Request Date or Request Effective Date in the case of a date range and therefore not eligible for Medicare.

Multiple periods of inactivity will be returned if there is any variation in the dates.

The system will return current eligibility information when no specific date request has been made on the 270 transaction (through 2100C DTP03 date).

The system will return a HIPAA qualifier with each EB Loop for MCO to indicate whether a Managed Care Organization (MCO) is a Health Maintenance Organization (HMO), a Point of Service (POS), Preferred Provider Organizations (PPO) or Fee for Service (Indemnity). Because of the wide variety of plan terms and conditions and the limited possible HIPAA compliant designations, it is not possible to reflect exact terms and conditions. The HETS 271 response will return only the most recent plan designation (HMO, PPO, POS, Indemnity, or Other) for a contract, even if the contract's plan designation has changed since the beneficiary originally enrolled in the contract. Trading Partners are advised to contact the plans if there is any question about the plan terms and conditions—especially for PPO and POS plans where terms vary widely. For information about how to contact plans go to http://www.cms.hhs.gov/MCRAdvPartDEnrolData/ and choose “Plan Directory for MA, Cost, PACE, and Demo Organizations (third from bottom) or “PDP Plan Directory” as needed.

MCOs that offer Prescription Drug Coverage will be returned twice, once with the “OT” designation to indicate Prescription Drug Coverage [EB*R**88*OT] and once with the appropriate qualifiers in 2110C EB04 for their terms and conditions for Part C Coverage.

5 271 Response Data Elements

If no service type codes are contained on the 270 transaction, or if a service type code is submitted in a 270 that does not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Reference Number		BHT	BHT03	Same as 270	All	M
Date & Time Stamp		BHT	BHT04, BHT05	System Date Time Stamp	All	M
Source ID	2100A	NM1	NM109	CMS	All	M
Provider Number	2100B	NM1	NM108	Same as 270	All	M
			NM109	Same as 270	All	M
		REF[1]	REF01	Same as 270	All	M
			REF02	Same as 270	All	M
Last Name	2100C	NM1	NM103	Subscriber Last Name[2]	All	M
First Name	2100C	NM1	NM104	Subscriber First Name[2]	All	M
Middle Initial	2100C	NM1	NM105	Subscriber Middle Initial[2]	All	M
Name Suffix	2100C	NM1	NM107	Subscriber Name Suffix[2]	All	M
HIC Number	2100C	NM1	NM108	MI	All	M
			NM109	Same as 270 or Active Cross-referenced HIC Number	All	M
		REF[3]	REF01	Q4	All	M
			REF02	Same as 270	All	M
Beneficiary Address Data	2100C	N3	N301	Address Line 1	All	M
			N302	Address Line 2		
		N4	N401	City Name	All	M
			N402	State Code		
			N403	Postal ZIP Code		
Date of Birth	2100C	DMG	DMG02	Same as 270	All	M
Gender Code	2100C	DMG	DMG03	Gender Code[2]	All	M
Eligibility Request Date	2100C	DTP	DTP01	307	All	M
			DTP02	D8/RD8		
			DTP03	Eligibility Request Start/End Dates		

[1] If multiple REF segments are sent, only the Medicare Provider Number or the National Provider Identifier will be returned.
[2] If there are errors in the transaction, these data elements will be the same as the 270. If a match is found, these data elements will be the values from the CMS Eligibility Database.
[3] REF in the 2100C loop is returned containing the HIC Number submitted on the 270 only when an active/cross referenced HIC Number is found and returned in the NM109.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Date of Death	2100C	DTP	DTP01	442	All	M
			DTP02	D8		
			DTP03	Date of Death		
Part A/B Entitlement/Term Dates	2110C	EB	EB01	1	All	M
			EB02	IND		
			EB04	MB or MA or omit EB04[4]		
		DTP[5]	DTP01	307	All	M
			DTP02	RD8, if entitlement and termination dates exist on Database, D8 if only entitlement date		
			DTP03	Entitlement/Term dates[6]		
Lifetime Reserve Days	2110C	EB	EB01	K	47/AG	A
			EB03	47		
			EB04	MA		
			EB06	33		
			EB09	LA		
			EB10	Days		
Deductible – Part A	2110C	EB	EB01	C	47	A
			EB03	47		
			EB04	MA		
			EB06	29		
			EB07	Deductible Amt		
		DTP	DTP01	435	47	A
			DTP02	RD8		
			DTP03	DOEBA-DOLBA		

[4] EB04 will be omitted when periods of ineligibility apply to both Medicare Part A and Medicare Part B.
[5] DTP will be included only if the inactive period is for a specific date range.
[6] When multiple entitlements are returned, they will occur in the descending order: future first, then current, then past.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Hospital Days Remaining[7]	2110C	EB	EB01	F	47/AG	A
			EB03	47		
			EB04	MA		
			EB06	29		
			EB09	DY		
			EB10	Days		
		DTP	DTP01	435	47/AG	A
			DTP02	RD8		
			DTP03	DOEBA-DOLBA		
Hospital Coinsurance Days Remaining[7]	2110C	EB	EB01	A	47/AG	A
			EB03	47		
			EB04	MA		
			EB06	29		
			EB07	amt. per day		
			EB09	DY		
			EB10	Days		
		DTP	DTP01	435	47/AG	A
			DTP02	RD8		
			DTP03	DOEBA-DOLBA		

[7] Hospital Days remaining and Hospital Coinsurance Days Remaining are related to a single Inpatient Spell. DOEBA and DOLBA days are related to the single Inpatient Spell and NOT to the individual Type of Service Code.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Skilled Nursing Facility Days Remaining[8]	2110C	EB	EB01	F	AG	A
			EB03	AG		
			EB04	MA		
			EB06	29		
			EB09	DY		
			EB10	Days		
		DTP	DTP01	435	AG	A
			DTP02	RD8		
			DTP03	DOEBA-DOLBA		
Skilled Nursing Facility Coinsurance Days Remaining[8]	2110C	EB	EB01	A	AG	A
			EB03	AG		
			EB04	MA		
			EB06	29		
			EB07	amt. per day		
			EB09	DY		
			EB10	Days		
		DTP	DTP01	435	AG	A
			DTP02	RD8		
			DTP03	DOEBA-DOLBA		

[8] Skilled Nursing Facility Days remaining and Skilled Nursing Facility Coinsurance Days Remaining are related to a single Inpatient Spell. DOEBA and DOLBA days are related to the single Inpatient Spell and NOT to the individual Type of Service Code.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Home Health Data – HHEH	2110C	EB	EB01	X	All	M
			EB03	42		
			EB04	MA		
			EB06	26		
		DTP	DTP01	193 (Period Start) 194 (Period End) 193 (Period DOEBA) 194 (Period DOLBA)	All	M
			DTP02	D8		
			DTP03	Start Date End Date DOEBA DOLBA		
		MSG	MSG01	"HHEH Start Date" "HHEH End Date" "HHEH DOEBA" "HHEH DOLBA"	All	M
	2120C	NM1	NM101	PR	42	A
			NM102	2		
			NM103	One of the following: "CAHABA GBA", "Associated Hospital Service", "Palmetto GBA", "United Government Services WI", "United Government Services, CA"		
			NM108	PI		
			NM109	One of the following: 00011, 00180, 00380, 00450, 00454		
		PRV	PRV01	HH	42	A
			PRV02	9K or HPI[9]		
			PRV03	Provider #		

[9] The legacy provider number will be returned if the NPI is not in the Information Source.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Deductible - Part B	2110C	EB	EB01	C	All	M
			EB03	96		
			EB04	MB		
			EB06	29		
			EB07	Deducible Amt		
		DTP	DTP01	292	All	M
			DTP02	RD8		
			DTP03	YYYY0101-YYYY1231		
Preventive Services	2110C	EB	EB01	D	All	M
			EB02	IND		
			EB04	MB		
			EB13-1	HC		
			EB13-2	HCPCS Code		
			EB13-3	HCPCS Modifier 26 (Professional Component) TC (Technical Component) Omit EB13-3 if the dates are the same.		
		DTP	DTP01	348	All	M
			DTP02	D8		
			DTP03	Next Eligible Date		
Smoking Cessation Sessions Remaining[10]	2110C	EB	EB01	F	All	M
			EB02	IND		
			EB03	67		
			EB04	MB		
			EB06	29		
			EB09	P6		
			EB10	Sessions remaining		

[10] Smoking Cessation Counseling Sessions Remaining will be returned when the beneficiary is eligible for Smoking Cessation Counseling with no waiting period; next eligible date will not be returned.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Smoking Cessation Next Eligible Date[11]	2110C	EB	EB01	D	All	M
			EB02	IND		
			EB03	67		
			EB04	MB		
		DTP	DTP01	348		
			DTP02	D8		
			DTP03	Next Eligible Date		
Occupational Therapy Caps[12]	2110C	EB	EB01	F	All	M
			EB02	IND		
			EB03	AD		
			EB04	MB		
			EB06	29		
			EB07	$ amount		
		DTP	DTP01	292		
			DTP02	RD8		
			DTP03	YYYY0101-YYYY1231		
Physical and Speech Therapy Caps[12]	2110C	EB	EB01	F	All	M
			EB02	IND		
			EB04	MB		
			EB05	“Physical and Speech Therapy”		
			EB06	29		
			EB07	$ amount		
		DTP	DTP01	292		
			DTP02	RD8		
			DTP03	YYYY0101-YYYY1231		

[11] Smoking Cessation Counseling Next Eligible Date will be returned when no Smoking Cessation Counseling sessions remain; sessions remaining will not be returned.

[12] Occupational Therapy Caps and Physical/Speech Therapy Caps will be implemented beginning from calendar year 2007. Therapy cap values for 2006 are not available.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
ESRD	2110C	EB	EB01	D	14/15	A
			EB03	14 or 15		
			EB04	MB or MA		
		DTP	DTP01	356	14/15	A
			DTP02	D8		
			DTP03	ESRD Effective Date		
		DTP	DTP01	198	14/15	A
			DTP02	D8		
			DTP03	Transplant Discharge Date		
		MSG	MSG01	"Transplant Discharge Date"	14/15	A
Hospice	2110C	EB	EB01	X	All	M
			EB03	45		
			EB04	MA		
			EB06	26		
		DTP	DTP01	292	All	M
			DTP02	D8/RD8		
			DTP03	Effective and/or Termination Dates		
	2120C	NM	NM101	1P	45	A
			NM102	2		
			NM108	SV or XX[13]		
			NM109	Provider #		
Blood Deductible Units	2110C	EB	EB01	C	All	M
			EB02	IND		
			EB03	10		
			EB06	29		
			EB09	DB		
			EB10	Number of Units		
		DTP	DTP01	292		
			DTP02	RD8		
			DTP03	YYYY0101-YYYY1231		

[13] The legacy provider number will be returned if the NPI is not in the Information Source.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
Part D Data	2110C	EB	EB01	R	All	M
			EB03	88		
			EB04	OT[14]		
		REF	REF01	18	All	M
			REF02	Contract Number and Plan Number separated by a space		
		DTP	DTP01	292	All	M
			DTP02	RD8, if enroll & dis-enroll dates exists, D8 if only enroll Date		
			DTP03	Part D Enrollment - Dis-enrollment Dates		
	2120C	NM1	NM101	PR	All	M
			NM102	2		
			NM103	Plan Name		
		N3	N301	Payer Addr Line 1	All	M
			N302	Payer Addr Line 2		
		N4	N401	Payer City	All	M
			N402	Payer State Code		
			N403	Payer ZIP Code		
		PER	PER01	IC	All	M
			PER03	TE		
			PER04	Telephone Number (format AAABBBCCCC)[15]		

[14] Medicare will use the "OT" qualifier to represent Part D plans per the ANSI ASC X12N 270/271 version 005010X279 which states "When this code is returned by Medicare or a Medicare Part D administrator, this code indicates a type of insurance of Medicare Part D."
[15]Telephone numbers will be sent when the data becomes available.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
MCO Data	2110C	EB	EB01	R	All	M
			EB03	30		
			EB04	HN, IN, PR, PS		
		REF	REF01	18	All	M
			REF02	Contract Number and Plan Number separated by a space. If a Plan Number is unavailable only the Contract Number will be in this element.		
		DTP	DTP01	290	All	M
			DTP02	RD8, if enroll & dis-enroll dates exists, D8 if only enroll Date		
			DTP03	MCO Enrollment / Dis-enrollment Dates		
	2120C	NM1	NM101	PRP	All	M
			NM102	2		
			NM103	Insurer Name		
		N3	N301	MCO Addr Line 1	All	M
			N302	MCO Addr Line 2		
		N4	N401	MCO City	All	M
			N402	MCO State Code		
			N403	MCO ZIP Code		
		PER	PER01	IC	All	M
			PER03	TE		
			PER04	Telephone Number (format AAABBBCCCC)[16]		

[16] Telephone numbers will be sent when the data becomes available.

Data Element Name	LOOP	SEGMENT	ELEMENT	DATA VALUE	270 Service Type Code (EQ01)	(M)inimum or (A)dditional
MSP Data	2110C	EB	EB01	R	All	M
			EB02	IND		
			EB03	30		
			EB04	MSP Code: 12, 13, 14, 15, 16, 41, 42, 43, 47		
		REF	REF01	IG	All	M
			REF02	Policy Number		
		DTP	DTP01	290	All	M
			DTP02	RD8, if effective/term exist on Database, D8 if only effective date		
			DTP03	MSP Effect/Term Dates		
	2120C	NM1	NM101	PRP	All	M
			NM102	2		
			NM103	Insurer Name		
		N3	N301	MSP Addr Line 1	All	M
			N302	MSP Addr Line 2		
		N4	N401	MSP City	All	M
			N402	MSP State Code		
			N403	MSP ZIP Code		